DCHC CDM MODEL
A Commitment to Change

Community

- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action

Downtown Community Health Clinic

- Information Systems
- Self-Management Support
- Decision Support
- Delivery System Design

The Model for Improvement

[Diagram of the Model for Improvement]

[PDCA Cycle]

[Steps: Plan, Do, Check, Act]
Commitment to Change

Downtown Community Health Clinic

Chronic Disease Management Model
Who we are...

Verity BuSkard
Jennifer Laing
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Purpose of the Synthesis Project

UBC nursing school synthesis projects pair nursing school students with community health partners to collaborate on projects to improve health care delivery within their organizations.
Purpose of our partnership with DCHC

We worked closely with Barb Eddy and Adrienne Jinkerson to develop project parameters.

Need identified: Systematic approach to chronic disease management

Aim: to develop an user-friendly, and clinic-specific Chronic Disease Management (CDM) model that can be used for improving the quality of chronic disease care at DCHC.
Vision

Model will complement and contribute to the realization of DCHC’S goal of achieving excellence in inner city primary health care.
Our Process

Initial project meeting with Barb Eddy

Research into QI and CDM

Looked at multiple models

Models most used and evidence-based:
Expanded Chronic Care Model and Model for Improvement

Bi-weekly meetings to validate research and findings

Outside consultation with Vancouver Native Health
Background

**BC Expanded Chronic Care Model**
Adapted from Chronic Care Model (Improving Chronic Illness Care, 2012) - used worldwide and effective in improving care in health systems
Recommended by BC ministry of health and used by Vancouver Coastal Health Authority
Broad reaching, non-agency specific, theoretical

**Tailoring the model to DCHC:**
Our aim was to create a model of chronic disease management that is:
- DCHC Specific
- Practical
- Applicable
- Measurable

Combining the Expanded Chronic Care Model with the Model for Improvement:
- Worked with DCHC to bring QI process into a tailored CDM model.
- Added and removed components to compliment DCHC vision and needs.

**The Model for Improvement**
Tool for accelerating change and improve system processes and outcomes.
Expansion of Plan-Do-Study-Act (PDSA) cycle.
BC Expanded Chronic Care Model

- Adapted from Chronic Care Model (Improving Chronic Illness Care, 2012) - used worldwide and effective in improving care in health systems

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- Broad reaching, non-agency specific, theoretical.
Population Health Outcomes / Functional & Clinical Outcomes
The Model for Improvement

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Tailoring the model to DCHC:

Our aim was to create a model of chronic disease management that is:

- **DCHC Specific**
- **Practical**
- **Applicable**
- **Measurable**

Combining the Expanded Chronic Care Model with the Model for Improvement:

- Worked with DCHC to bring QI process into a tailored CDM model.
- Added and removed components to compliment DCHC vision and needs.
No need to reinvent the wheel

Going beyond evidence-based theory to create relevant, practical and simple steps for management of change.

Valid to tailor model to organizational needs.

Not complete model

If those needs should change, so too should the model = A living model.
CDM model:

Underpinning for any change initiative.

Outlines broad areas for continual change and improvement

Within each heading are examples and suggestions for focusing change projects.

Coming to the CDM model is first step in any change initiative.
Model for improvement:

Takes identified area for improvement from CDM model and accelerates change process within that area.

Steps:
  I. Create an aims statement for what you’re trying to achieve
  II. Decide how you’re going to measure your success
  III. Decide on intervention you’re going to do
  IV. Try intervention using PDSA cycle.
  V. Evaluate successes and modify interventions as necessary.
  VI. Begin PDSA cycle again.
Using the Model

This model requires input from stakeholders to capture the relevance of stakeholders' day-to-day experience.
Build Healthy Public Policy
- Advocate for policies to improve patient care.
  - Advocating for and participating in DTES population-specific research.

- Develop and implement policies designed to improve population health (Barr et. al., 2003)
  - Lobby government for healthy public policies that support DTES population.
Create Supportive Environments
- Conduct thorough assessments of community supports to identify gaps in programs and services.
- Assess community supports for accessibility and for potential barriers to access.
Strengthen Community Action
- Build and strengthen partnerships with community organizations (Improving Chronic Illness Care, 2012)
- Build and strengthen university and community partnerships.
- Empower target community (Barr et al, 2003).
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Information Systems

Self-Management Support

Decision Support

Delivery System Design
Downtown Community Health Clinic

- Information Systems
- Self-Management Support
- Decision Support
- Delivery System Design
Self-Management Support
• Patient’s role in care and management:
  - Ensure patient has a central role in managing her or his health (Rand et al., 2006);
    • Patient develops personal health goals
    • Develop collaborative health goals
      o SMART goals: specific, measurable, achievable, resources available, and timely.
    • Assess patient readiness for change using change theory (Schaefer, 2007).
    • Identify barriers to change and strategies to address these (Schaefer, 2007)
    • Identify barriers to medication/treatment concordance
  • Care team support
    o Clinician implements current research and evidence-based tools
      o Treatment planning
    o Appropriate referrals
    • Care Plans
      o EMR, flowsheets, and documentation
  - Establishing contact with relevant community resources
    • Friend and family inclusion in care
    • Group involvement
    • Peer Support
  • Patient Education
    • Share evidence-based information with patients (Render et al., 2001; Rand et al., 2006)
    • Use proven education methods for clients (Rand et al., 2006)
    • Improve illness-specific health literacy of patients (BC Ministry of Health, 2011)
    • Confirm patient understanding of knowledge
Decision Support
- Incorporate evidence-based practice guidelines into daily clinic practice (Rand et. al, 2006)
- Bring in value-added Specialist expertise and primary care into client care (Rand et. al, 2006)
- Family meeting and case conferencing opportunities
- Resources on alternative, evidence-based treatment options
- Apply the Transtheoretical Model of Change to develop clinician support strategies and training (BC Ministry of Health, 2011)
- Clinician continuing education opportunities
- Identify relevant sub-populations who may need more involved care (Rand et. al, 2006), and provide sub-populations with tailored support
- Enact informed consent principles
  - Comprehensive patient education
  - Provide opportunities for second opinion
  - Informed consent forms
  - Ongoing patient-clinician dialogue
- Create policy for decision support
Delivery System Design
- Clearly identify practice team roles, functioning and leadership (Bonomi et al., 2002; Rand et al., 2006)
- Evidence-based, standardized visit schedule for chronic care management (Bonomi et al., 2002)
- Ensure continuity of care, internally and externally (Bonomi et al., 2002)
- Planned screening and vaccinations
- Assign case manager for clients with complex health issues (Rand et al. 2006)
- Provide culturally-sensitive, inclusive care (Rand et al. 2006)
- Discuss delivery system challenges through formal communication systems (meetings, feedback forms, etc.)
Information Systems
· Ensure timely appointment reminders (Renders et. al., 2001; Rand et. al, 2006).
· Document and communicate individualized care plans (Rand et. al, 2006)
· Share information between patient/family and providers to coordinate care (Rand et. al, 2006)
· Train care providers in EMR
· Register patients by specific illness/condition (Bonomi et. al, 2002)
· Develop quick-access process for looking at patient treatment plans (Bonomi et. al, 2002)
· Track treatment results, compliance, patient satisfaction, outcomes, etc.
· Create year-to-year statistics to measure treatment effectiveness and outcomes (Renders et. al., 2001)
· Input patient demographic data accurately (Graf et. al, 2012)
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The Model for Improvement

Aim

Measure

Change

PDSA

Identify appropriate intervention/implementation
Aim

- Create a goal statement
- Diagnose problem in specific areas
- State purpose and scope of goal
- Form a QI team, including relevant stakeholders (ImpactBC, 2012)

Measure

- Establish measurable objectives - SMART goals
- Establish indicators of success

Change

- Identify appropriate intervention(s) (ImpactBC, 2012)
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Change

- Identify appropriate intervention(s) (ImpactBC, 2012)
Plan
- Identify appropriate models/guidelines/pathways/etc. to use
- Appraise available funding and resources
- Foster staff buy-in
  - Examples:
    - Garner staff feedback and support
    - Staff education and training relevant to change
    - Quality improvement literacy
· Apply intervention to practice
Study
- Measure impact of intervention based on SMART goal indicators
- Evaluate success
- Write report on outcomes
- Identify if objectives are achieved
- Consider modifications to plan and alternative solutions (Chronic Illness Care, 2012)
- Begin cycle again
Measure

- Establish measurable objectives - SMART goals
- Establish indicators of success

Change

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